



Add a Person Form

To add people in your household to Healthy Families

Instructions

- Use this form for any people in your home you would like to add to Healthy Families. To add more than 4 people, copy this form.
- Use this form for unborn children who are due to be born within 90 days. After a baby is born, mail a copy of the birth document to Healthy Families within 30 days. Coverage for the baby will start 13 days after we get the document.
- For each person who is a U.S. citizen or national, you must **send a copy of a birth certificate within 2 months**. For people who are not U.S. citizens or nationals, you must send **proof of immigration status within 2 months**.

Questions?

If you have any questions about the form, call Healthy Families: **1-866-848-9166**, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m.

The call is free.

Family Member Number:

People to add ➡		Person 1	Person 2	Person 3	Person 4
Name ➡	First name				
	Middle name				
	Last name				
Birth name ➡ (if different from name above)	First name				
	Middle name				
	Last name				
Address ➡ (if different from applicant's)	Street				
	City				
	Zip Code				
Relationship to applicant					
Sex		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth (or expected date)					
Birth place (California county, other state or other country)					

Questions about these persons continue on next page.

Questions? Call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or Saturday, 8 a.m. to 5 p.m. The call is free.

People to add, <i>continued</i> ➡		Person 1	Person 2	Person 3	Person 4
Ethnicity What is the ethnic (cultural) background of each person?		<input type="checkbox"/> white <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Amerasian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> other	<input type="checkbox"/> white <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Amerasian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> other	<input type="checkbox"/> white <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Amerasian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> other	<input type="checkbox"/> white <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Filipino <input type="checkbox"/> Amerasian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> other
U.S citizen or national?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, write date of entry into U.S.					
Social Security Number: <i>(You do not have to write this)</i>					
Mother's name ➡ (required for children)	First name				
	Last name				
Does the mother live in the home?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father's name ➡	First name				
	Last name				
Does the father live in the home?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the person earns income, how much per month? <i>See the Family Members and Income brochure about what to list.</i>		\$ From where?	\$ From where?	\$ From where?	\$ From where?
Does this person have no-cost Medi-Cal? If yes, give date coverage will end		<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Questions about these persons continue on next page.



Add a Person Form, Page 3

People to add, *continued* ➔

	Person 1	Person 2	Person 3	Person 4
Did this person have health insurance from an employer in the last 90 days? If yes, check the main reason why insurance stopped.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> lost or changed job <input type="checkbox"/> moved, no insurance available <input type="checkbox"/> employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> reached maximum coverage of benefits <input type="checkbox"/> death, legal separation or divorce <input type="checkbox"/> other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> lost or changed job <input type="checkbox"/> moved, no insurance available <input type="checkbox"/> employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> reached maximum coverage of benefits <input type="checkbox"/> death, legal separation or divorce <input type="checkbox"/> other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> lost or changed job <input type="checkbox"/> moved, no insurance available <input type="checkbox"/> employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> reached maximum coverage of benefits <input type="checkbox"/> death, legal separation or divorce <input type="checkbox"/> other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> lost or changed job <input type="checkbox"/> moved, no insurance available <input type="checkbox"/> employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> reached maximum coverage of benefits <input type="checkbox"/> death, legal separation or divorce <input type="checkbox"/> other: _____
Write date insurance stopped.				

Adults in the household

Name of adult	Relationship to applicant	Relationship to children	Gross income amount (income before taxes)	How often is the person paid?
	Applicant		\$	<input type="checkbox"/> once every week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month <input type="checkbox"/> once a month
			\$	<input type="checkbox"/> once every week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month <input type="checkbox"/> once a month



Expenses

Childcare expenses you pay each month for <u>children under age 2</u> . The maximum amount allowed is \$200.	\$ Send proof
Childcare expenses you pay each month for children <u>age 2 and over</u> . The maximum amount allowed is \$175.	\$ Send proof
Disabled dependent care expenses you pay each month. The maximum amount allowed is \$175.	\$ Send proof
Monthly court ordered alimony you pay	\$ Send proof
Monthly court ordered child support you pay.	\$ Send proof
For each working parent, we will deduct up to \$90 for work-related expenses.	
Is the applicant or anyone else in the home pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name? _____	

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature: _____ **Date:** _____

Permission to forward Add a Person Form to Medi-Cal: If this person/child is ineligible for Health Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of anyone applying for full scope Medi-Cal benefits.

Applicant Signature: _____ **Date:** _____